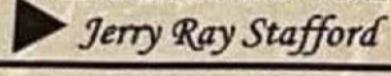
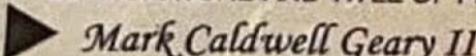
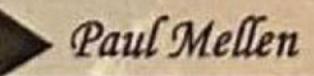
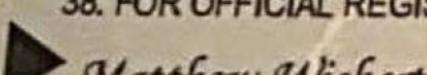


EXHIBIT F

NAME OF DECEASED Alvis Ray Shrewsbury	1. DECEASED'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)				2. GENDER	3. SOCIAL SECURITY NUMBER		
	Alvis Ray Shrewsbury		Male					
	4a. AGE (Last Birthday) (Years)	4b. IF UNDER 1 YEAR		4c. IF UNDER 1 DAY		5. DATE OF BIRTH (MM/DD/YYYY)		
		45	Month	Days	Hours	Minutes		
	7a. RESIDENCE (STATE) West Virginia		7b. COUNTY Wyoming		6. BIRTHPLACE (City and State or Foreign Country) Mullens, West Virginia			
	7d. STREET AND NUMBER 3917 Herndon Road				7e. APT. NO.	7f. ZIP CODE 24716	7g. INSIDE CITY LIMITS?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT.		STREET & NUMBER		APT. NO.	CITY OR TOWN	COUNTY	STATE ZIP
	8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown		10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)			
	11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Willie Shrewsbury				12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Anna Lou Perry			
	13a. INFORMANT'S NAME Miranda Dawn Smith		13b. RELATIONSHIP TO DECEASED Daughter		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) PO Box 303, Bud, WV, 24716			
14. PLACE OF DEATH (Check only one: see instructions)								
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival				IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify):				
15. FACILITY NAME (If not institution, give street & number) Beckley Appalachian Regional Hospital		16. CITY OR TOWN, STATE, AND ZIP CODE Beckley, West Virginia 25801				17. COUNTY OF DEATH Raleigh		
18. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):		19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.) Thomas Wayne Shrewsbury Cemetery						
20. DISPOSITION LOCATION (City, State) Stephenson, WV		21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY Stafford Family Funeral Home 143 Cler Fork Road, Oceana, West Virginia, 24870						
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH 						23. LICENSE NUMBER (Of Licensee) 3761		
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH				24. DATE PRONOUNCED DEAD (MM/DD/YYYY) 09/17/2022			25. TIME PRONOUNCED DEAD 02:07 AM	
26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.) 						27. DATE SIGNED (MM/DD/YYYY) 09/19/2022		
28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) 09/17/2022 Actual			29. ACTUAL OR PRESUMED TIME OF DEATH 02:07 AM Actual		30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes IF YES, MEDICAL EXAMINER CASE # 2206566			
CAUSE OF DEATH								
31. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute and chronic upper gastrointestinal bleeding Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST b. <<>>> Due to (or as a consequence of): c. <<>>> Due to (or as a consequence of): d. <<>>> Due to (or as a consequence of):								
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I. Cardiomegaly				32a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No			
33. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		34. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the last year		35a. CAUSE/MANNER PENDING? <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Date Amended 11/04/2022	35b. FINAL MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
36a. DATE OF INJURY (MM/DD/YYYY)		36b. TIME OF INJURY		36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area)				
36e. LOCATION OF INJURY: Street & Number:		Apt No.:		City or Town:		State or Country:		
36f. DESCRIBE HOW INJURY OCCURRED				36g. IF TRANSPORTATION INJURY: ROLE: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		SEATBELT RESTRAINT STATUS: <input type="checkbox"/> Restrained <input type="checkbox"/> No restraint <input type="checkbox"/> Unknown HELMET STATUS: <input type="checkbox"/> Helmet <input type="checkbox"/> No helmet <input type="checkbox"/> Unknown		
37a. CERTIFIER (Check only one): <input type="checkbox"/> Certifying Physician or Qualified APRN / PA - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & Certifying Physician or Qualified APRN / PA - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner/Coroner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.								
Signature of Certifier 				Electronically Signed		Date Certified 09/19/2022		
37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.) Paul Mellen 619 Virginia Street W, Charleston, WV 25302						37c. TITLE OF CERTIFIER Medical Examiner		
38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR 						39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED 09/30/2022		



G0596558

Date Certified: Nov 09 2022

STATE OF WEST VIRGINIA

This is to certify that this document is a true and accurate reproduction of an official record, or the facts abstracted from an official record, on file with:

Vital Statistics
Bureau for Public Health
West Virginia Department of Health and Human Resources
Charleston, West Virginia.

Matthew R. Wickert
Matthew R. Wickert
State Registrar



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